| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 005109 | A. BUILDING: _____ B. WING _____ | 04/25/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY HOSPITAL SOUTH | 1402 E COUNTY LINE RD S INDIANAPOLIS, IN 46227 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | INITIAL COMMENTS<br><br>This visit is for a State hospital complaint investigation.<br><br>Complaint: #IN00120379<br>Unsubstantiated -lack of sufficient evidence.<br><br>Survey Date: 04/25/13<br><br>Facility: # 005109<br><br>Surveyor: Linda Dubak, R.N.<br>Public Health Nurse Surveyor<br><br>Community Hospital South is in compliance with 410 IAC 15-1.6-4, Out-patient services for Indiana Hospital Licensure rules.<br><br>QA: claughlin 05/23/13 | S 000 | | |